

C. People of Color

(NOTE: Information is reported by specific sub-populations of communities of color, based on data from consumer surveys and focus groups and provider surveys and key informant interviews. Data tables include aggregate statistics from consumer survey respondents who identified as African American (n=59), Latino/Latina (n=56) or Asian/Pacific Islander (n=21). The number of Native Americans/Alaska Natives (n=10) and Africans (n=11) who responded to the survey is insufficient from which to develop useful data tables for these populations or on which to run tests for statistical significance. As a result, information presented regarding PLWH from these populations is based primarily on key informant provider interviews and focus group responses.)

“The more outreach provided to minority communities regarding HIV/AIDS services, the better. Reaching the medical providers who serve these communities is equally important to assure that every doctor who has a patient who tests positive knows where to refer that patient for services and support.” (Case manager)

1. Epidemiologic Profile

In Seattle-King County, as in the United States as a whole, epidemiologic data indicate that HIV and AIDS have disproportionately affected African Americans, Native Americans/Alaska Natives, and persons of Hispanic ethnicity compared to Whites or Asian/Pacific Islanders. The racial disparity is even greater among women of color compared to men of color.

Status and trends in AIDS cases, with population sizes: Of the total of 8,400 estimated King County residents currently living with HIV infection (including those with AIDS), an estimated 2,250 (27%) are people of color. By race/ethnicity, the estimated number of HIV-infected persons includes approximately 6,150 (73%) non-Hispanic Whites, 1,240 (15%) African Americans, 690 (8%) persons of Hispanic ethnicity, 180 (2%) Asians/Pacific Islanders and 140 (2%) Native Americans/Alaska Natives. As of 12/31/2002, 770 African Americans, 412 non-Hispanic Whites, 108 Asians/Pacific Islanders and 84 Native Americans/Alaska Natives were reported to Public Health and presumed living with HIV or AIDS in King County.

The percent of newly-diagnosed HIV/AIDS cases among people of color has risen steadily since the early years of the epidemic in King County, increasing from 12% of cases in 1982-1987 to 27% in 1994-1996 and to 38% in 2000-2002. This trend has been most evident among African American and Hispanic persons. Population based HIV rates from 2000-2002 demonstrate the epidemic's disproportionate impact on persons of color, with rates among African Americans, Latino/as and Native American/Alaska Natives being two to five times that of Whites in King County. HIV/AIDS rates among Asian/Pacific Islanders, however, continue to be significantly lower than Whites (Table 24).

Racial disparities are greatest among African American women compared to women of other races/ethnicities. In 2000-2002, the average annual rate of HIV/AIDS for African American females (446 per 100,000) in King County was 13 times greater than that of White females (30 per 100,000). Rates among Native Americans/Alaska Natives (307 per 100,000) and Latinas (83

per 100,000) were also substantially higher than the rates for White women, but these rates must be interpreted with caution due to the small case numbers among Native American and Latina women.

Table 24. Comparison of King County Racial Composition with New HIV Diagnoses (2000-2002)

	King County (est. 2000 pop.)	(% of pop.)	HIV/AIDS cases (2000-2002)	(% of cases)	AIDS case rate per 1000,000 population
White	1,309,130	(75%)	651	(62%)	16.6
African American	105,205	(6%)	234	(22%)	74.1
Latino/Latina	95,242	(6%)	110	(11%)	38.5
Asian/Pacific. Islander	210,156	(12%)	31	(3%)	4.9
Nat. Amer./AK Native	17,311	(1%)	12	(1%)	23.1
TOTAL	1,737,034	(100%)	1,043	(100%)	20.0

More African American and Native American/Alaska Native men and women acquire HIV from injection drug use as compared to other groups. The percent of AIDS cases by race for selected HIV exposure categories for males and females are given in Table 25.

Table 25. AIDS Cases by Race and Selected HIV Exposure Categories (6/02)

MALES (N=4,648)	White	Afr-Am	Latino/a	A/PI	NA/AN
MSM non-injectors	82%	51%	72%	76%	50%
MSM drug injectors	11%	7%	6%	4%	32%
Heterosexual drug injectors	3%	13%	10%	4%	15%
Heterosexual non-injectors	1%	13%	3%	3%	2%
Undetermined/not reported	2%	16%	9%	13%	2%
FEMALES (N=454)	White	Afr-Am	Latino/a	A/PI	NA/AN
Drug injectors	28%	20%	6%	0%	64%
Heterosexual non-IDU	47%	45%	58%	38%	18%
Heterosexual non-injectors	2%	4%	3%	8%	0%
Perinatal exposure	3%	4%	6%	8%	0%
Undetermined/not reported	20%	27%	28%	46%	18%

HIV seroprevalence: Seroprevalence data from unlinked surveys from the Harborview Sexually-Transmitted Disease (STD) Clinic indicate higher rates of HIV among heterosexual African American and Hispanic men and women compared to Whites. In Clinic surveys conducted in 2000-01, 0.2% of heterosexual Whites (n=1,504) tested HIV positive, compared to 0.7% of African Americans (n=562) and 0.7% of Hispanics (n=146). No heterosexual Asians/Pacific Islanders (n=746) since 1990 or Native Americans/Alaska Natives (n=265) since 1992 have tested positive in this survey.

2. Service Trends

African Americans: Providers of services to African American PLWH reported that their client caseloads are predominantly male, with increasing numbers of women entering the service system in the past two years. Similar to epidemic figures, African American survey respondents were significantly more likely than Whites to be female (32% versus 7%) and report heterosexual transmission risk (27% versus 3%). African American survey respondents were equally as likely to live in Seattle as White respondents (81% versus 82%).

In previous years, African American survey respondents were significantly more likely than Whites to report homelessness. In 2003, this gap has narrowed, with 20% of African American respondents reporting homelessness in the past year versus 13% of Whites. Providers of services to African American PLWH noted a somewhat higher rate of homelessness in their caseloads, reporting that 25% to 33% of their African American clients have experienced homelessness.

African American survey respondents reported rates of mental illness that were significantly lower than Whites (44% versus 60%). However, providers reported that a large and growing numbers of their clients suffer from depression. Many clients have long-term histories of mental health problems, although many are resistant to psychotherapy or are in denial about the need to seek professional help.

According to providers, substance use issues continue to be widespread among African American PLWH, with between 50%-75% of clients reported as having substance abuse histories. Crack cocaine is reported as the main drug of choice, followed by heroin. The majority of clients are not engaged in treatment programs. Alcohol abuse is also high in this population, with providers estimating that as many as 75%-90% of their clients abuse alcohol. African American survey respondents were no more likely than Whites to report injection drug use (9% versus 8%), but were almost three times as likely to report using non-injectable cocaine (25% versus 9%).

African Americans were slightly less likely to report themselves as AIDS disabled than White PLWH (54% versus 66%). However, African Americans were significantly more likely than Whites to report not knowing their current T-cell counts (24% versus 5%) or their viral loads (24% versus 6%). Providers noted that many of their African American clients are entering care later in their diagnoses and experiencing declining health.

Providers noted that access to HIV-related medications is not a problem for their African American clients. In prior years, providers reported that adherence with medication regimens was a concern. In 2003, providers noted that client compliance has improved significantly. Some clients, however, continue to demonstrate adherence challenges due to medication side effects and substance use.

Despite these positive changes, African American PLWH survey respondents continue to be significantly less likely than Whites to be taking antiviral medications (56% versus 77%). In previous years, African American PLWH were also less likely than Whites to be taking protease inhibitors, medications to treat or prevent opportunistic infections, and medications for HIV-

related side effects. These disparities have lessened considerably in the past two years, with the rate of African Americans taking each of these medications being fairly similar to Whites. African American survey respondents reported higher utilization rates of most services than did White consumers. African Americans were significantly more likely than Whites to use a wide variety of services, including help finding housing (46% versus 28%), peer or client advocacy (50% versus 28%), emergency financial assistance (55% versus 30%), treatment adherence support (54% versus 35%), one-on-one peer support (47% versus 27%), fresh or canned food programs (62% versus 46%), alcohol and/or non-injection drug use treatment (29% versus 13%), telephone referrals to medical and dental care (64% versus 39%), and adult day health programs (28% versus 14%).

Of note is the growing number of HIV+ African refugees who have immigrated to King County. On the 2003 provider survey, respondents reported that three percent of their aggregate consumer caseloads were foreign-born Africans. The largest groups are from Ethiopia and Eritrea, but many other African countries are represented. Twenty-five of the 182 provider survey respondents (14%) reported seeing one or more clients whose primary language was an African dialect (e.g., Eritrean, Somali, Swahili, etc.). Approximately one-third of these clients are women. Most of the African PLWH live in Seattle's Rainier Valley or in South King County.

Providers of services to African refugee PLWH report that their clients are generally in good health. Once introduced to the HIV care system, the clients have had good access to medical care and prescription medications. Co-morbidities such as mental illness and substance use are rare in this population.

"I always think I am alone. I think people are afraid. I've decided never to enter into any more relationships, because I don't want to pass on HIV. My case manager says it can be safe, but I'm afraid." (African immigrant PLWH)

Latino/Latinas: On the 2003 provider survey, respondents reported a higher percentage of Latino/a clients than in any previous survey year. The overall percent of Latino/a clients rose from 8% in 2001 to 11% in 2003, with the number of clients reported as being primarily Spanish speaking increasing from 5% in 2001 to 7% in 2003.

Providers of services to Latino/a PLWH reported that their client caseloads are increasingly female (between 10%-33% of total reported caseloads). While the difference is not as marked as with African American survey respondents, Latino/a survey respondents were significantly more likely than Whites to be female (18% versus 7%) and to have been exposed to HIV through heterosexual contact (39% versus 3%).

Hispanic consumer survey respondents were significantly more likely than Whites to report living in South King County (24% versus 9%). Providers reported that most of their male Latino clients reside in Seattle, although a higher proportion reside in non-Seattle King County than White males. Hispanic female PLWH are dispersed throughout South King County. Latino/a consumer survey respondents were over twice as likely as White PLWH to report homelessness in the past year (30% versus 13%).

Severe mental illness does not appear to be as predominant in this population as in other populations. Providers do report that clinical depression is fairly common (and increasing), although few clients access treatment for it. Forty-one percent of Latino/a PLWH reported being diagnosed with some form of mental illness, including clinical depression. This rate is still significantly lower than for Whites (60%).

Substance use seems to be less widespread in the Latino/a PLWH population than among Whites or African Americans. Rates of injection and non-injectable drug use are less than half those reported in these other populations. Providers noted that alcohol abuse is the “drug of choice” for many of their Latino/a clients.

No trends emerged regarding the point at which clients entered care, with providers seeing clients along the entire spectrum of HIV disease. HIV-related health status was also reported as variable, although Latino/a survey respondents were significantly less likely than Whites to report being AIDS disabled (49% versus 66%). Consistent with prior years, Latino/a clients were four times more likely than Whites to be unaware of their T-cell counts (20% versus 5%) and more than three times more likely to be unaware of their viral loads (20% versus 6%).

Providers noted few problems for their clients in accessing HIV-related medications. However, knowledge of treatment options is relatively low, particularly for female clients. As first reported in 2001, adherence problems with HAART regimens continue to be high. The percent of Latino/a PLWH who reported taking at least one type of HIV-related medication was slightly lower than for Whites, but not statistically significant.

Unlike previous years, Latino/a survey respondents reported higher utilization rates than White PLWH in most service categories. Latino/a consumers were significantly more likely than Whites to use help finding housing (46% versus 28%), help paying rent (57% versus 39%), grocery vouchers (40% versus 26%), telephone referrals to medical and dental care (64% versus 39%), and adult day health programs (44% versus 14%). Not surprisingly, Latino/a consumers were significantly more likely than other PLWH sub-populations to use interpreter services (52% of Latinos/as versus 7% of all other consumers). Consistent with provider reports, Latino/a PLWH demonstrated significantly lower utilization of mental health services (37% versus 58% of Whites), due largely to cultural norms against seeking this type of assistance.

Asian/Pacific Islanders: Providers report seeing very small numbers of A/PI clients. HIV transmission is predominantly related to MSM activity among male A/PI clients and heterosexual risk for female A/PI. No significant differences emerged regarding sex and mode of transmission among A/PI survey respondents (n=21) and Whites. Clients represent a wide spectrum of Asian nationalities and languages, primarily Vietnamese, Cambodian, Chinese and Thai. Although most clients speak at least limited English, language barriers continue to be an issue for recent immigrants.

Providers reported that many of their clients reside in South Seattle and South King County. A/PI consumer survey respondents were slightly more likely than Whites to reside in non-Seattle King County. Rates of homelessness in this population are also reported as being similar to

White PLWH.

Providers noted a high rate of depression among their A/PI clients, with lower rates of other mental illnesses compared to other populations. Clients were described as generally resistant to seeking professional mental health counseling, primarily due to cultural norms. A significantly lower percentage of A/PI survey respondents reported having been diagnosed with mental illness than did Whites (38% versus 60%).

Substance use appears to be far less common among A/PI PLWH than in other populations. Several providers reported no active substance use (including alcohol abuse) among their A/PI client caseloads. No A/PI survey respondents reported using injection drugs, and the rate of cocaine use was less than half that for White PLWH. Reported alcohol abuse was lower than for all other populations.

“I am living with HIV. Like diabetes or renal failure, it is my constant and unwelcome companion, but I feel we walk together. Sometimes whistling, sometimes silent, we are not afraid.” (Asian MSM PLWH)

Providers report that their A/PI clients who are more integrated into the larger community and who do not have language and cultural barriers are seeking services from a wide variety of HIV/AIDS service providers. Those clients who are first generation A/PI are more likely to restrict their services to agencies targeting Asian communities. Service utilization among these clients is reported to have risen somewhat in the past two years, but cultural issues and lack of trust in mainstream providers remain as barriers.

A/PI survey respondents reported similar utilization rates as White PLWH in most service categories. Utilization rates for A/PI were significantly higher than Whites for case management (90% versus 73%), peer or client advocacy (79% versus 28%), and one-on-one emotional support (47% versus 27%). A/PI clients were also more likely than White PLWH to use interpreter services (29% versus 4%). Consistent with provider reports, A/PI PLWH were significantly less likely than Whites to use mental health services (30% versus 58%).

Native American/Alaska Natives: Providers of service to Native Americans and Alaska Natives report that their caseloads are predominantly male. Transmission risk among men is predominantly through homosexual activity, although these men may not self-identify as gay or bisexual. Among women, heterosexual transmission is most common. Among the small number of Native American/Alaska Native survey respondents (n=10), injection drug use was a relatively more common mode of transmission than sexual transmission.

The majority of Native American PLWH live in Seattle. Providers report that at least half of their Native American clients have experienced homelessness in the past year. Survey respondents and focus group participants (n=5) also reported high rates of prior homelessness.

Providers report high rates of mental illness and substance use in the Native American PLWH population. Clinical depression is common, as are paranoid episodes secondary to substance use. Alcohol abuse is reported to be widespread among the Native American PLWH population.

Providers noted that approximately 75% of their Native American clients are current or former substance users, with crystal meth, crack cocaine and heroin being the “drugs of choice.” Providers reported that most of their Native American clients enter care late in their AIDS diagnosis. These clients are referred into HIV care through inpatient hospitalizations, the TB clinic, and from substance use treatment programs. Due to the small number of Native American survey respondents (n=10), it is not possible to derive comparisons of HIV-related health status and medication usage to other populations.

Native American survey respondents did report utilization rates that were fairly similar to White PLWH, although statistical comparisons are not possible. Providers noted that it often takes a longer period of time to engage Native American clients in services, sometimes requiring years of concerted effort. This is due to several factors, including cultural issues related to privacy and confidentiality, homelessness and chemical dependency. Once trust has been developed between provider and consumer, Native American clients tend to access a wide variety of services. Housing assistance is reported to be the most frequently requested service for this population.

3. Service Priorities

African Americans: Primary medical care tied with emergency financial assistance as the number one service priority for African American survey respondents (Table 26). These services were followed by case management, oral health care, the AIDS Drug Assistance Program, and housing assistance and housing related services.

African American consumers were significantly more likely than White PLWH to prioritize emergency financial assistance (65% versus 38%). African Americans were also significantly more likely to prioritize child care than Whites (15% versus 0%), due to the higher percentage of African American respondents who were women.

Table 26. Service Priorities: African Americans (n=55; 4 missing responses)

RANK	SERVICE	# OF VOTES	% OF RESP.
1 (tie)	Ambulatory/outpatient medical care	36	65%
1 (tie)	Emergency financial assistance	36	65%
3	Case management	33	60%
4	Oral health care	32	58%
5 (tie)	AIDS Drug Assistance Program	29	53%
5 (tie)	Housing assistance/related services	29	53%
7	Psychosocial support	23	42%
8	Health insurance	18	33%
9	Client advocacy	17	31%
10 (tie)	Legal services	15	27%
10 (tie)	Food bank/home-delivered meals	15	27%

Latino/Latinas: Latino/a survey respondents ranked housing assistance and housing related services as their number one service priority (Table 27). This was followed by oral health care, case management, emergency financial assistance, and health insurance. It is interesting to note that Latinos/as were the only consumer sub-population not to rank primary medical care among their top five service priorities (ranked 6th).

Table 27. Service Priorities: Latino/Latinas (n=53; 3 missing responses)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Housing assistance/related services	33	69%
2	Oral health care	28	58%
3	Case management	27	56%
4	Emergency financial assistance	26	54%
5	Health insurance	26	54%
6	Ambulatory/outpatient medical care	25	52%
7	AIDS Drug Assistance Program	23	48%
8	Food bank/home-delivered meals	16	33%
9 (tie)	Client advocacy	13	27%
9 (tie)	Psychosocial support	11	23%

Latino/a consumers were significantly more likely than Whites to prioritize housing assistance and related services (74% versus 45%). Providers noted that housing needs among their clients have increased in recent years, particularly due to the rising number of non-resident Latino/as who have moved into in King County. Latino/as were also significantly more likely than Whites to prioritize treatment adherence support programs (15% versus 6%). As previously noted, information about HIV treatments is generally more available in English and knowledge levels of HIV disease and treatment options are generally lower among Hispanic female PLWH.

Asian/Pacific Islanders: The limited number of Asian/Pacific Islander survey respondents (n=21) identified similar service priorities as other consumer sub-populations. The top service priority identified by A/PI PLWH was the AIDS Drug Assistance Program, followed by ambulatory medical care, oral health care, and emergency financial assistance (Table 28). It is interesting to note that Asian/Pacific Islander PLWH were the only consumer sub-population not to rank case management among their top five service priorities (ranked tied for 9th).

In particular, providers of services to this population stressed the importance of delivering services in a culturally competent manner, which takes into account the client's culture of origin. Because the range of languages spoken in the Asian/Pacific Islander communities is extensive, this requires that providers have access to a broad range of Asian language interpreters.

**Table 28. Service Priorities: Asians/Pacific Islanders
(n=19; 2 missing responses)**

RANK	SERVICE	# OF VOTES	% OF RESP.
1	AIDS Drug Assistance Program	16	84%
2 (tie)	Ambulatory/outpatient medical care	13	68%
2 (tie)	Oral health care	13	68%
4	Emergency financial assistance	11	58%
5 (tie)	Client advocacy	8	42%
5 (tie)	Transportation	8	42%
5 (tie)	Health insurance	8	42%
5 (tie)	Housing assistance/related services	8	42%
9 (tie)	Case management	7	37%
9 (tie)	Psychosocial support	7	37%

Native American/Alaska Natives: In general, the limited number of Native American survey respondents identified similar service priorities as other consumer sub-populations. These included primary medical care, the AIDS Drug Assistance Program, case management, emergency financial assistance and oral health care.

Providers of services to Native Americans and Alaska Natives noted that case management and client advocacy were extremely important for their clients. Most of their clients are dually or triply diagnosed (HIV, mental illness and chemical dependency), and need assistance with housing, financial and insurance issues. As a result, these clients may require more time and resources than other PLWH in order to help them access and maintain services.

4. Service Gaps

“I am very paranoid about sharing my health status with anyone. My T-cell count is low and my viral load is high. I’ve only told those I have to, to try and survive.” (African American female PLWH)

African Americans: African American PLWH ranked emergency financial assistance, housing assistance, psychosocial support, legal services and child care among their top five service gaps (Table 29). Within the emergency financial assistance category, African Americans reported fairly equal gaps in grocery vouchers (22%) and help paying for utilities (21%). In the housing category, African American clients were more likely to identify a gap in help paying rent (27%) than in help finding housing (9%).

As first seen in 2001, African American PLWH were fairly similar to White consumers in their identification of service gaps. The only categories in which African American consumers

identified significantly greater gaps than Whites are child care (17% versus 4%) and transportation (15% versus 5%).

Table 29. Service Gaps: African Americans (n=59)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Emergency financial assistance	16	27%
2	Housing assistance/related services	14	24%
3 (tie)	Psychosocial support	13	22%
3 (tie)	Legal services	13	22%
5	Child care	10	17%
6	Transportation	9	15%
7 (tie)	Client advocacy	8	14%
7(tie)	Food bank/home-delivered meals	8	14%
9	Buddy/companion care	7	12%
10	AIDS Drug Assistance Program	6	10%

Latino/Latinas: Consistent with rankings from the past two rounds of surveys, Latino/a survey respondents ranked emergency financial assistance as the largest service gap in the Continuum of Care. This was followed by legal services, housing assistance, psychosocial support and alternative/non-Western therapies (Table 30). Within the emergency financial assistance category, Latino/as noted a slightly higher gap in grocery vouchers (38%) than in help paying for utilities (33%).

Table 30. Service Gaps: Latino/Latinas (n=56)

RANK	SERVICE	# OF VOTES	% OF RESP.
1	Emergency financial assistance	22	39%
2 (tie)	Legal services	17	30%
2 (tie)	Housing assistance/related services	17	30%
4	Psychosocial support	16	29%
5	Alternative, non-Western therapies	15	27%
6	Mental health services	14	25%
7	Client advocacy	13	23%
8	Food bank/home-delivered meals	12	21%
9	Oral health care	10	18%
10 (tie)	Child care	9	16%
10 (tie)	Referral for health care services	9	16%

Latino/Latina consumers identified statistically higher service gaps than other populations in a broader range of service categories. Among the categories in which these consumers identified

greater gaps are legal services (30% versus 17% of all other consumers), mental health services (25% versus 12%), client advocacy (23% versus 13%), food and meal programs (21% versus 11%), child care (16% versus 5%), and health education and risk reduction (11% versus 3%).

Asian/Pacific Islanders: A/PI consumer survey respondents ranked housing services and emergency financial assistance as tied for their top service gap, followed by legal services (Table 31). Due to the relatively low number of A/PI clients who identified service gaps, no category emerged as a significantly higher gap than for other sub-populations.

**Table 31. Service Gaps: Asians/Pacific Islanders
(n=21)**

RANK	SERVICE	# OF VOTES	% OF RESP.
1 (tie)	Housing assistance/related services	6	29%
1 (tie)	Emergency financial assistance	6	29%
3	Legal services	4	19%
4 (tie)	Alternative, non-Western therapies	3	14%
4 (tie)	Transportation	3	14%
4 (tie)	Oral health care	3	14%
4 (tie)	Mental health services	3	14%
8	Food bank/home delivered meals	2	10%

Note: 10 services received one mention each as a service gap

As with Latinos and Native Americans, providers stated that service gaps were largely dependent on the degree of integration into the mainstream culture exhibited by their clients. For clients who are familiar with and comfortable using HIV/AIDS services, few gaps exist. However, for those who are recent immigrants or for whom English is not their first language, effective case management and client advocacy is vital in accessing medical and social services.

Native American/Alaska Natives: The low number of Native American/Alaska Native survey respondents (n=10) makes it impossible to constructively rank service gaps for this sub-population. Nevertheless, Native American PLWH ranked emergency financial assistance, oral health care and psychosocial support as tied for the highest service gap. Each of these services was identified as a gap by four of the ten survey respondents. As previously mentioned, providers of services to this population noted that the main challenge in working with this population is developing trust as a prelude to engagement in care and services.

“I have a very small income. I am seriously struggling to maintain my private health insurance payment, which has gone up to almost \$500 a month. I need help, but I am not yet disabled and I want to keep my health insurance as long as possible.” (Native American male PLWH)

5. Unmet Need for Medical Care

African Americans: Ninety-two percent of African American respondents to the consumer survey reported currently receiving primary care for their HIV infection, similar to rates reported by Whites and other sub-populations. All of the participants in the African American focus group (n=6) were currently engaged in primary care and none had experienced any notable challenges in accessing care in King County.

Several participants in the African American focus group stated that they were aware of HIV-infected peers who were not currently accessing medical care. They suggested that the main barrier for these individuals was denial about their infection. Other barriers included fear of being stigmatized in the community and substance use issues. They felt that heightened visibility of HIV information and education in the African American community was needed to overcome these barriers. Providers were in agreement with these opinions, noting that access to care was relatively easy for their clients once they were ready to engage in services.

The main barrier identified to enrolling and maintaining African immigrant PLWH in medical care was navigating complicated insurance systems. Most of these clients are in relatively stable health and many are receiving health care coverage through their employers. However, members of this population are generally unfamiliar with the American health care system, and are less able to make informed choices about their care and coverage options.

Latinos/as: Ninety-four percent of Latino/a PLWH respondents to the consumer survey reported currently receiving primary care for their HIV infection. All of the participants in the Latino/a focus group (n=6) were currently engaged in primary care and none had experienced significant challenges in accessing care in King County. They were particularly grateful to their case managers who had helped them access services and medical care.

“We need more Spanish speaking medical providers so that you don’t have to have a third person interviewer in your business.” (Latina female PLWH)

Latino/a focus group participants expressed frustration and concern that they had not been tested for HIV earlier in their disease progression. Many of these individuals were surprised to find out that HIV testing had not been part of their routine medical care. As a result, several had experienced hospitalizations and severe symptoms before it was suggested to them that they be tested for HIV. They were surprised that confidentiality issues in the United States appear to supercede what they perceive to be necessary medical care. This highlights the need for providers to address potential HIV risk in the Latino/a population, and incorporate informed HIV prevention, testing and counseling into their service delivery.

Providers reported barriers in helping their Latino/a clients access medical coupons and insurance coverage. Their clients are unfamiliar with the DSHS and DOH systems, and find the paperwork and bureaucracy confusing.

Asians/Pacific Islanders: Similar percentages of Asian/Pacific Islanders reported medical care utilization as other sub-populations (94%). As previously noted, it was not possible to convene an A/PI focus group due to lack of participant registration. However, providers reported that

most of their A/PI clients are engaged in medical care and that few access barriers exist for their enculturated clients. Language and cultural issues continue to serve as barriers for non- or limited-English speakers. It is just as important for these clients to trust their interpreters as it is that they trust their medical and social service providers. This may necessitate a “one client/one interpreter” system, because there are many Asian communities in King County, and confidentiality within each of these can be a significant concern.

Providers also noted that preventive medical care is not a common cultural concept. As a result, clients may only access care when they are very sick. This highlights the need for increased education and outreach in A/PI communities regarding the benefits of early intervention and treatment for HIV infection.

Native Americans/Alaska Natives: Nine of the ten Native American/Alaska Native survey respondents reported current utilization of primary medical care. All of the Native American focus group participants (n=5) were engaged in medical care and had seen a doctor within the past six months. Several participants noted that they had specifically moved to Seattle to access medical care, because they felt that the quality of HIV care available to them in the city was superior to what was available on their reservations or in other rural areas.

In prior years, Native American focus group participants revealed that they were aware of other members of their community who were HIV-infected but not engaged in care. The 2003 focus group did not express similar sentiments. Providers stressed that access to care was not an issue for their Native American clients, but that developing trust with these clients was an extended process that necessitated persistent and ongoing efforts.

Estimates of PLWH who are “not in care”: In early 2003, Public Health – Seattle & King County and the Washington State Department of Health (DOH) convened a work group across Titles I and II. The group adapted a framework for calculating unmet need for primary care that was developed for HRSA by a team from the University of California, San Francisco (UCSF). (A comprehensive discussion of how the Seattle EMA planned its “not in care” estimate process and derived its figures is contained in Part IV, Section H, “Unmet Need for Medical Care.”)

Estimates of unmet need included sub-population analysis based on sex, race/ethnicity and HIV/AIDS status. As a result, it is possible to quantify the number of King County PLWH who are persons of color who are believed to be not in care (defined locally as not having had a T-cell or viral load test in the past twelve months). Based on adjusted laboratory report data, the following estimates have been developed:

- 23.2% of all King County African American PLWH who are aware of their serostatus are currently “not in care.” This represents approximately 200 African Americans. (95% confidence range: 173 low estimate and 229 high estimate).
- 28.2% of all King County Latino/a PLWH who are aware of their serostatus are currently “not in care.” This represents approximately 131 Latino/as. (95% confidence range: 109 low estimate and 155 high estimate).
- 15.7% of all King County Native American/Alaska Native PLWH who are aware of their

serostatus are currently “not in care.” This represents approximately 15 Native Americans/Alaska Natives. (95% confidence range: 8 low estimate and 24 high estimate).

- 32.8% of all King County Asian/Pacific Islander PLWH who are aware of their serostatus are currently “not in care.” This represents approximately 42 A/PI PLWH. (95% confidence range: 30 low estimate and 56 high estimate).

Based on the UCSF framework, an estimated 23.5% of White PLWH are believed to be “not in care.” Although the estimated “not in care” percentages are lower for Native American PLWH and slightly higher for other racial/ethnic sub-groups, these differences are not statistically significant.

Useful surrogate markers to quantify persons not in care come from the Seattle site of the CDC-funded Adult/Adolescent Spectrum of Disease (ASD) project. Data gathered in this project include information about persons who received a “late diagnosis” with HIV (diagnosed with HIV at the time of their AIDS diagnosis, or within three months of the AIDS diagnosis). This provides a picture of persons across racial/ethnic categories who were not in care for their HIV infection prior to receiving a diagnosis of AIDS. Results from the ASD project reveal that:

- 32.2% of African American PLWH (91 out of 283) who received an AIDS diagnosis during the period of 1996-2001 received a “late diagnosis” of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 35.2%.
- 39.2% of Latino/a PLWH (58 out of 148) who received an AIDS diagnosis during the period of 1996-2001 received a “late diagnosis” of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 47.1%.
- 28.6% of Asian/Pacific Islander PLWH (10 out of 35) who received an AIDS diagnosis during the period of 1996-2001 received a “late diagnosis” of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 28.6%.
- 33.3% of Native American/Alaska Native PLWH (11 out of 33) who received an AIDS diagnosis during the period of 1996-2001 received a “late diagnosis” of HIV. In 2001, the last complete reporting year, the percentage of late diagnoses in this population was 42.9%.

Comparable figures for White PLWH indicate that 19.4% (94 out of 485) received late diagnoses of HIV during the 1996-2001 time period. In 2001, the percentage of late diagnoses among White PLWH was 28.3%. Within the various racial/ethnic categories, Latinos are more likely to receive late diagnoses, both cumulatively and among recently tested persons.

These figures suggest that persons of color across all racial/ethnic categories are more likely than White PLWH to receive late diagnoses of HIV. Increased counseling and testing efforts directed towards communities of color are necessary, as are heightened culturally-specific education efforts to inform individuals at risk about the benefits of early intervention, treatment and medical care.

